Brown County Public Health: Vaccine Consent Form

Please check the vaccines your child should receive:

- ☐ **Tdap**
- ☐ **HPV**
- ☐ **Hepatitis A**
- ☐ **MMR**
- ☐ **Hepatitis B**
- ☐ **TD**
- ☐ **Meningitis**
- ☐ **Flu Shot (If Available)**
- ☐ **Varicella**
- ☐ **Polio**

☐ **I am unsure what vaccines my child needs. I would like the Brown County Public Health to review my child's information in WIR (Wisconsin Immunization Registry). Based on the information in WIR, I authorize the Brown County Public Health to administer any vaccines listed on this consent form that are recommended/needed for his/her age. I understand I will be provided with information on what vaccines will be given at the school based clinic prior to administration of vaccine.**

Student Name (Last, First, Middle initial) please print				Male Female
Date of Birth	Age	Parent/Guardian Name		Telephone Number ( )
Address		City	State	Zip Code
School				

Please Circle Yes or No

Does the child have any allergies to medications, food, a vaccine component or latex? List:_____	YES	NO
Has the child had a serious reaction to a vaccine in the past?	YES	NO
Has the child had a health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma or a blood disorder? Is he/she on long-term aspirin therapy?	YES	NO
Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	YES	NO
Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES	NO
In the past 3 months, has the child taken medications that weaken his/her immune system, such as cortisone, prednisone, other steroids, anticancer drugs or had radiation treatments?	YES	NO
In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	YES	NO
Is the person to be vaccinated pregnant or is there a chance that she could become pregnant in the next month?	YES	NO
Has the child received any vaccination during the past 4 weeks? List: _____	YES	NO

CONSENT FOR VACCINATION: I have read, or have had explained to me, the Vaccine Information Statement for the vaccine (available online at www.co.brown.wi.us/health). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given the person named above for whom I am authorized to make this request. Brown County Public Health will bill Medical Assistance if the child is covered by that program. I understand that a record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) and with other health care providers directly involved with the vaccinated person's care. This consent form authorizes the administration of multiple doses of a vaccine, if medically indicated. This consent form will expire after the last vaccination is given in a vaccine series.

Parent/Guardian Signature _____ **Date** _____

FOR OFFICE USE:

Student's Name:_____ **DOB:**_____**School:**_____

WIR Reviewed: _____ **WIR Reviewed**: _____

Vaccines to be given: **Vaccines to be given:**

Tdap	**Meningococcal**	**HPV**	**FLU**		**Tdap**	**Meningococcal**	**HPV**	**FLU**
Hep A	**Hep B**	**MMR**			**Hep A**	**Hep B**	**MMR**	
Td	**IPV**	**Varicella**			**Td**	**IPV**	**Varicella**	

Initials/ Date: _____ **Initials/ Date**: _____

Notes: _____

Clinic Date: **Date VIS provided:**

Is the child well today?	**Yes**	**No**				**Initials:**_____		
Tdap (IM)	LD	RD	Meningococcal (IM)	LD	RD	HPV (IM)	LD	RD
Hep A (IM)	LD	RD	Hep B (IM)	LD	RD	MMR (Sub Q)	LD	RD
Td (IM)	LD	RD	Polio (Sub Q)	LD	RD	Varicella(Sub Q)	LD	RD
Flu(IM)	LD	RD						
Signature/Title of vaccine Administrator:						Date:		

(LD-Left Deltoid RD-Right Deltoid)

Notes:_____

WIR Reviewed: _____ **WIR Reviewed**:_____

Vaccines to be given: **Vaccines to be given:**

Tdap	**Meningococcal**	**HPV**	**FLU**		**Tdap**	**Meningococcal**	**HPV**	**FLU**
Hep A	**Hep B**	**MMR**			**Hep A**	**Hep B**	**MMR**	
Td	**IPV**	**Varicella**			**Td**	**IPV**	**Varicella**	

Initials/ Date: _____ **Initials/Date:** _____

Notes: _____

_____

Clinic Date: **Date VIS provided:**

Is the child well today?	**Yes**	**No**				**Initials:**_____		
Tdap (IM)	LD	RD	Meningococcal (IM)	LD	RD	HPV (IM)	LD	RD
Hep A (IM)	LD	RD	Hep B (IM)	LD	RD	MMR (Sub Q)	LD	RD
Td (IM)	LD	RD	Polio (Sub Q)	LD	RD	Varicella(Sub Q)	LD	RD
Flu(IM)	LD	RD						
Signature/ Title of Vaccine Administrator:						Date:		

(LD-Left Deltoid RD-Right Deltoid)

Notes:_____

*Only vaccines highlighted were administered at the clinic